

# Patient Medical History

Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Chart # \_\_\_\_\_

Are you allergic to any medications?  YES  NO If yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine)?  YES  NO Any bad reaction?  YES  NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

<b>Lungs:</b>	YES	NO	<b>Other Systemic:</b>	YES	NO
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hypo	<input type="checkbox"/>	<input type="checkbox"/>
			Hyper	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular:</b>	YES	NO	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
<b>Defibrillator</b>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/Prostate	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pacemaker</b>	<input type="checkbox"/>	<input type="checkbox"/>	Bowels	<input type="checkbox"/>	<input type="checkbox"/> Specify: _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/> Specify: _____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea or		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	yeast infection when taking		
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics	<input type="checkbox"/>	<input type="checkbox"/> Specify: _____
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia/Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/> Specify: _____
Inflammation of leg			Limited Motion	<input type="checkbox"/>	<input type="checkbox"/>
veins	<input type="checkbox"/>	<input type="checkbox"/>	<b>Artificial Joint</b>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<b>Enlarged Lymph nodes</b>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN:</b>	<b>YES</b>	<b>NO</b>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/> Specify: _____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Family history of skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____		
Skin diseases	<input type="checkbox"/>	<input type="checkbox"/>			
Problems with healing	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____		
Develop keloids?	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____		
Easy bleeding/bruising?	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____		
Skin rashes?	<input type="checkbox"/>	<input type="checkbox"/>			
Dryness?	<input type="checkbox"/>	<input type="checkbox"/>			
Reactions to:	<input type="checkbox"/> Bandages	<input type="checkbox"/> Latex			

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

## Social History:

Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day  
Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you smoke?  YES  NO If Yes, how much? \_\_\_\_\_  
Have you had or have you been exposed to HIV (AIDS)?  YES  NO  
Have you had or have you been exposed to Hepatitis A, B, or C?  YES  NO

Please answer the following question: **(Women) Are you pregnant?**  YES  NO Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

\_\_\_\_\_  
Signed by Patient/Parent or Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date